Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR JT DILGER JR

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-10-4320-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 9, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam. DDE. Return to Work DDE."

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated June 28, 2010: "First, the requestor has failed to include copies of the original medical bill submitted to the carrier, or the bill submitted for reconsideration. Second, the requestor has not included a copy of all Explanations of Benefits received, or clear and convincing evidence of the carrier's receipt of the requestor's request for an Explanation of Benefits. Finally, the carrier has tendered reimbursement to the requestor as payment in full for the services rendered, and thus, a dispute no longer exists. The service underlying the disputed medical bill is a designated doctor evaluation. The carrier submits that it has tendered reimbursement to the requestor for services rendered. The check number is 133603."

Respondent's Supplemental Position Summary dated March 23, 2012: "Please see attached payment screen showing that the Carrier sent an additional $16.49 to Dr. Dilger on 3/11/2011."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2009	CPT Codes 99456-W5, 99456-W5, and 99456-W8	$1,150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

Issues

Is the requestor entitled to additional reimbursement?

Findings

A review of the Table of Disputed Services finds that the requestor listed $1,150.00 as the amount in dispute. The respondent supported position that a payment of $1,150.00 was issued for the disputed services with check number 133603. As a result, the dispute has been resolved and additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		04/04/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.